January 3, 2000

FOR: The Commissioners
FROM:: William D. Travers /RA/

Executive Director for Operations

SUBJECT: REPORT TO CONGRESS ON ABNORMAL OCCURRENCES FOR FISCAL YEAR 1999

- PURPOSE:
- DISCUSSION:
 - NRC FUEL CYCLE LICENSEE
 - OTHER NRC LICENSEES (Industrial Radiographers, Medical Institutions, Industrial Licensees etc.)
 - AGREEMENT STATE LICENSEES
 - NUCLEAR POWER PLANTS
 - OTHER NRC AND AGREEMENT STATE MATERIALS LICENSEES
 - Agreement State Licensees
 - NRC Licensees
- COORDINATION:
- RECOMMENDATION:
- SCHEDULING:

PURPOSE:

To obtain Commission approval to submit the abnormal occurrences (AOs) report to Congress.

DISCUSSION:

This paper presents a draft of the "Report to Congress on Abnormal Occurrences Fiscal Year 1999" (NUREG-0090, Vol. 22) (Attachment 1 🌦). An accident or event will be considered an AO if it involves a major reduction in the degree of protection of public health or safety. Specific AO criteria are discussed in Appendix A of Attachment 1 🌦.

The draft report addresses a total of 13 AOs: 4 AOs at facilities licensed or otherwise regulated by NRC and 9 AOs at facilities licensed by Agreement States.

The AOs discussed in this report are:

NRC FUEL CYCLE LICENSEE

99-1 Fire Breaches Containment and Requires Shutdown of a Portion of the Cascade at the Portsmouth Gaseous Diffusion Plant in Piketon, Ohio

OTHER NRC LICENSEES (Industrial Radiographers, Medical Institutions, Industrial Licensees etc.)

- 99-2 Medical Event Involving the Administration of Iodine-131 to a Pregnant Patient at St. Joseph Health Center in Kansas City, Missouri
- 99-3 Medical Event Involving the Administration of Iodine-131 to a Pregnant Patient at Camden-Clark Memorial Hospital in Parkersburg, West Virginia
- 99-4 Sodium Iodide Radiopharmaceutical Misadministration at Holy Redeemer Hospital and Medical Center in Meadowbrook, Pennsylvania

AGREEMENT STATE LICENSEES

- AS 99-1 Medical Event Involving the Administration of Iodine-131 to a Pregnant Patient at Via Christi Regional Medical Center in Wichita, Kansas
- AS 99-2 Industrial Radiography Occupational Overexposure at Global X-ray and Testing Corporation in Aransas Pass, Texas
- AS 99-3 Industrial Radiography Overexposure to a Member of the Public at Professional Service Industries, Inc. in Seattle, Washington

- AS 99-4 Gamma Stereotactic Radiosurgery (Gamma Knife) Misadministration at University of Maryland Medical Systems in Baltimore, Maryland
- AS 99-5 Gamma Stereotactic Radiosurgery (Gamma Knife) Misadministration at Good Samaritan Hospital in Los Angeles, California
- AS 99-6 Therapeutic Radiopharmaceutical Misadministration of Iodine-131 to the Wrong Individual at Hermann Hospital in Houston, Texas
- AS 99-7 Therapeutic Radiopharmaceutical Misadministration of Iodine-131 to the Wrong Individual at Milton Hospital in Milton, Massachusetts
- AS 99-8 Therapeutic Radiopharmaceutical Misadministration of Samarium-153 at Merle West Medical Center in Klamath Falls, Oregon
- AS 99-9 Sodium Iodide Radiopharmaceutical Misadministration at St. Edward Mercy Medical Center in Fort Smith, Arkansas

Appendix B of Attachment 1 is reserved for updates of previously reported abnormal occurrences. There are no updates for this report.

Appendix C, "Other Events of Interest," contains events that do not meet the AO criteria but that are perceived to be of interest to Congress. The guidelines for determining events to be considered for inclusion are listed in Appendix A. Appendix C contains two events involving nuclear power plants and one issue with two examples.

The proposed Appendix C events are as follows:

NUCLEAR POWER PLANTS

- 1. Fire in Hydrogen Storage Facility at James A. FitzPatrick
- 2. Scram and Partial Loss of Vital Power at Indian Point Unit 2

OTHER NRC AND AGREEMENT STATE MATERIALS LICENSEES

The proposed Appendix C includes a brief discussion of a loss of control of licensed materials issue and provides the following examples for illustration:

Agreement State Licensees

1. Loss of a Radiography Camera Owned by NDT and Inspections at Pembroke Pines, Florida

NRC Licensees

2. Improper Firing of Depleted Uranium Munitions in Viegues Island, Puerto Rico

Included with this paper are a proposed draft letter to the President of the Senate (Attachment 2) and the Speaker of the House (Attachment 3) forwarding the AO report for Fiscal Year 1999.

COORDINATION:

The Office of the Chief Financial Officer has reviewed this Commission paper for resource implications and has no objections. The Office of the General Counsel has reviewed the draft report and has no legal objections to its contents.

RECOMMENDATION:

That the Commission approve the contents of the proposed AO report to Congress for FY 1999 and the proposed letters to Congress forwarding the AO report.

When approval is received, the staff will submit the letters to the President of the Senate and the Speaker of the House to the Chairman for signature. The Office of Congressional Affairs will then arrange for appropriate distribution to Congress. The NRC staff will issue a *Federal Register* notice describing the NRC and Agreement State licensee AOs and announcing publication of the report.

SCHEDULING:

It is requested that the Commission take action within two weeks of receipt of this draft report.

William D. Travers **Executive Director for Operations**

CONTACT: Harriet Karagiannis, RES

301-415-6377

Attachments: 1. Draft of "Report to Congress on Abnormal Occurrences Fiscal Year 1999" 🎥

2. Letter to President of the Senate

3. Letter to Speaker of the House

ATTACHMENT 2

The Honorable Albert J. Gore, Jr. President of the United States Senate Washington, D.C. 20510

Dear Mr. President:

I am forwarding our "Report to Congress on Abnormal Occurrences Fiscal Year 1999" for events at nuclear facilities. This report is required by Section 208 of the Energy Reorganization Act of 1974 (Public Law 93-438). In the context of the act, an abnormal occurrence (AO) is an unscheduled incident or event that the Commission determines to be significant from the standpoint of public health or safety. The Federal Reports Elimination and Sunset Act of 1995 (Public Law 104-66) requires that AOs be reported to Congress annually.

The report addresses four AOs at facilities licensed or otherwise regulated by NRC. One event involved a fire that breached containment and required shutdown of a portion of the cascade at a gaseous diffusion plant. Two medical events involved the administration of radioactive material to pregnant women and one event involved a sodium iodide misadministration. The report also addresses nine AOs at facilities licensed by Agreement States. Agreement States are those States that have entered into a formal agreement with NRC pursuant to Section 274 of the Atomic Energy Act (AEA) to regulate certain quantities of AEA material at facilities located within their borders. Currently, there are 31 Agreement States. One of the Agreement State AOs involved the administration of radioactive material to a pregnant woman, two involved overexposures of an occupational worker and a member of the public at industrial radiography operations, two involved gamma stereotactic radiosurgery misadministrations, three involved therapeutic radiopharmaceutical misadministrations, and one involved sodium iodide misadministration.

Sincerely,

Richard A. Meserve

Enclosure: "Report to Congress on Abnormal Occurrences Fiscal Year 1999"

ATTACHMENT 3

The Honorable J. Dennis Hastert Speaker of the United States House of Representatives Washington, D.C. 20515

Dear Mr. Speaker:

I am forwarding our "Report to Congress on Abnormal Occurrences, Fiscal Year 1999" for events at nuclear facilities. This report is required by Section 208 of the Energy Reorganization Act of 1974 (Public Law 93-438). In the context of the act, an abnormal occurrence (AO) is an unscheduled incident or event that the Commission determines to be significant from the standpoint of public health or safety. The Federal Reports Elimination and Sunset Act of 1995 (Public Law 104-66) requires that AOs be reported to Congress annually.

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radiosurgery misadministrations, three involved therapeutic radiopharmaceutical misadministrations, and one involved sodium iodide misadministration.

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Richard A. Meserve

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